2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4001 Fatality	1/21/04 Kasson	Construction worker	Construction 1761 235610 2	Victim fell 12' – 15' from scaffold on residential construction site	Serious citations issued for no written AWAIR program [182.653 subd. 8], failure to provide fall protection [1926.451(g)(1)], and failure to attach bracket scaffolds to the supporting form work or structure by a bolt extending through to the opposite side of the structure's wall [1926.452(g)(1)].
4002 Fatality	3/8/04 Biwabik	Mechanic	Explosives Manufacturer 2892 325920 13	Victim was working on a personal vehicle. The vehicle fell off the jack stands and crushed the victim. Appears victim was using a sledgehammer to remove the front axle and the vehicle shifted.	No citations issued. Victim was not working for the employer at time of accident.
4003 Serious Injury	1/13/04 Bryon	Press Assistant	Printing 2759 323121 500	Employee was cleaning pan rollers. The employee stumbled and put his hand on the roller just as the operator jogged the press. Employee's hand went into the roller and he partially amputated his finger.	Serious citations for general duty, specifically, lack of written procedures [183.653, subd. 2]; AWAIR program not updated & lack of safety committee meetings [182.653, subd. 8]
4004 Serious Injury	3/8/04 Faribault	Laborers & Owners	Roofing 1761 235610 2	Two employees and 2 owners were putting shingles on a roof. The scaffold they were standing on came loose and the four workers fell 25' to the ground.	Serious citations for inadequate program & lack of training on AWAIR [182.653, subd. 8]; lack of fall protection on scaffold [1926.451(g)(1)]; bracket scaffold not properly attached to supporting structure [1926.452(g)(1)]
4005 Serious Injury	3/9/04 Chanhassen	Laborer	Lumber Dealer 5211 444190 750	Employee was assisting in unloading & stacking lumber. A bundle of lumber fell off of a stack of 5 tiers, hit the ground, broke apart and hit & partially buried the employee. Employee suffered broken bones & fractures in low back.	No citations issued. No standards violated.

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4006 Fatality	3/8/04 Fridley	Maintenance Asst.	Plastics 3086 326150 72	Victim and another employee were repairing a cylinder that had broken free from its housing on a compactor. The cylinder was jammed and the employees decided to turn the machine on and off to jog the cylinder. The cylinder broke free, hit the wall, then hit the back of the victim's head.	Serious citations for: LOTO procedures not developed or utilized [1910.147(c)(4)(i)]; inadequate LOTO training [1910.147(c)(7)(i); LOTO devices (group locks and/or tags) were not utilized [1910.147 (f)(3)(i) & (ii)].
4007 Fatality	3/12/04 Marine on St. Croix	Tree Trimmer	Tree Service 0783 561730 2	Employee walked into path of falling tree and was struck.	No citations issued. No employment relationship.
4008 Serious Injury	4/6/04 Medina	Carpenter	Siding Contractor 1521 236115 12	Driver hand cranking load of 2x4's (3599 lbs) 48" off truck. The victim was under load retrieving a tool. When it was lowered, the load struck and pinned the victim.	No citations issued. No standards violated.
4009 Serious Injury	4/8/04 Eagan	Maintenance	Mtg. Wood Products 2439 321214 190	Employee suffered severe burns while completing the electrical installation of a saw. He was making electrical connections inside the switch enclosure (switch was energized) when his uninsulated wrench or pliers slipped and made contact between adjacent conductors, or conductors and ground.	Serious citations for: inadequate LOTO procedures [1910.147(c)(4)(i) & (ii)], lack of LOTO training [1910.147(c)(7)(i)]; lack of ESWP training [1910.333(b)(1)], lack of ESWP procedures [1910.333(b)(2)(i)], unqualified persons allowed to work on energized electric equipment [1910.333(c)(2)]; lack of proper PPE, PPE not maintained, insulated hand tools not used [1910.335(a)(1)(i), (ii), & (v), and (a)(2)(i)]
4010 Serious Injury	4/14/04 Edina	Baker	Bakery 2051 311812 30	Employee walking between bun and bread machines when he slipped and fell, his arm entered the uncovered area on the side of the bread machine that had an exposed chain and sprocket. The bread machine was operating and entangled the victim's forearm in the machine.	Serious citation issued for failure to enclose sprocket wheels or chains seven feet or less above floors or platforms [1910.219(f)(3)]and failure to maintain injury and illness logs [1904.29(a)].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4011 Serious Injury	4/14/04 Red Wing	Maintenance	Leather Tanning 3111 316110 265	Employee was cleaning a rooftop rotary star valve. This was not shut off properly and employee's right hand was caught in valve resulting in fingertip and finger amputation. Employee also suffered a stress related heart attack during the surgery.	Serious citation for lack of LOTO procedures & failure to certify LOTO training [1910.147(c)(4)(i) & (c)(7)(iv)
4012 Fatality	4/23/04 Vadnais Hgts	Diver	Diver 7389 561790 2	Diver was working on aeration system with one other diver. Diver was found entangled in cables.	No citations issued. No employment relationship.
4013 Serious Injury	4/28/04 Greenbush	Volunteer Fire Fighter	Fire Fighter 9111 921110 52	Training exercise in a condemned house. Glass windows shattered, feeding oxygen to fire, causing a flashover. Employee suffered burns through fire suit while exiting house.	Serious citations for general duty, specifically, lack of training [182.653, subd. 2]; PPE lack of training [1910.132(f)(1) & (4)]; lack of training and failure to ensure fire resistance clothing met requirements [1910.156(c)(1) & (e)(3)(iii); lack of RTK program [5206.0700, subps. 1, 2 & 3]
4014 Serious Injury	5/18/04 Minneapolis	Recycling Supervisor	Machinery Repair 7699 811310 35	Propane vapors from the scavenging operation were ignited by a welder's torch causing 1st and 2nd degree burns on victim.	Willful citations for venting LP gas into atmosphere through an opening larger than a #31 drill within 50 feet of important building [1910.110(b)(14)(iv)]; welding in the presence of explosive atmospheres [1910.252(a)(2)(vi)(C)]; and serious citations for failure to provide fire watcher when welding in locations where other than a minor fire might develop [1910.252(a)(2)(iii)(A)]; failure to ensure supervisor was responsible for safe handling and use of cutting or welding equipment and safe use of welding process [1910.252(a)(2)(xiv)(A)].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4015 Fatality	6/1/04 Hampton	Laborer & Owner of 2 companies on worksite	Excavation 1794 238910 8	Installing water main. Victim was helping guide a pipe being moved by a backhoe. Backhoe boom contacted overhead power lines and victim was electrocuted.	Serious citations for: working too close to energized overhead lines, no insulating barriers, no signal person [1926.550(a)(15), 1926.0600(a)(6)]; other citations not related to accident were issued.
4016 Fatality	6/7/04 Crane Lake	Mechanic - Welder	Recreation Service 7999 487990 35	Victim was welding a float on a houseboat when the section being welded exploded. The float section had previously been used to store gasoline and was not properly cleaned or vented prior to welding.	Serious citation for failure to thoroughly clean tank, failure to vent tank to permit escape of gases & failure to make certain there were no flammable materials present prior to welding [1910.252(a)(3)(i) & (ii)].
4017 Fatality	6/7/04 Montevideo	Apprentice Lineman	Communication & Power Line 1623 237130 79	Employees were assigned to remove ground wires from a tower. An employee removed a ground clamp that was still attached to the line phase using a tool that was not an approved insulated tool (lanyard clamp), resulting in electrocution.	Serious citations for: general duty, failure to provide direct supervision of apprentice linemen [182.653, subd. 2]; failure to determine existing conditions by an inspection or test before starting work [1926. 950(b)(1)]; employees were permitted to work closer to exposed energized parts than the distance allowed [1926.950(c)(1)]; grounding device shall be removed using an approved insulated tool [1926.954(e)(2)]; failure to instruct employees in the recognition and avoidance of unsafe conditions [1926.21 (b)(2)].
4018 Fatality	6/12/04 Chanhassen	Receiving Operator	Frozen Pastries 2053 311813 10,000	Turned down wrong aisle with forklift and hit cross brace of racking. Pinned between forklift and rack brace.	No citations issued. No standards violated.

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4019 Serious Injury	5/11/04 Chaska	Press operator	Metal Products 3499 332999 12	Press double stroked and employee suffered a crushing injury to the left hand.	Serious citations for: single stroke/continuous mode selector toggle switch was not capable of being supervised & there was no prior action or pre-set button to enable continuous operation [182.653, subd. 2]; failure to locate point of operation safety devices at required safe distance [1910.217(c)(1)(i) & (c)(3)(viii)]; failure to establish die setting procedures [1910.217(d)(9)(i)]; failure to train personnel responsible for maintaining & inspecting power presses [1910.217(e)(3)]; failure to train press operators in safe method of work [1910.217(f)(2)].
4020 Fatality	6/24/04 Elysian	Non-employee	Excavation 1794 238910 15	Putting air in tire of a large front end loader. Split rim struck victim in the head	No inspection. No employment relationship. Victim was visiting maintenance garage.
4021 Serious Injury	7/2/04 Hopkins	Shift lead-Mfg	Structural metal work 3449 332312 38	Employee reached into a mechanical power press to free a stuck part. The press cycled and the employee's hand was amputated at the wrist.	Serious citations for: failure to utilize LOTO, incomplete procedures, no annual inspection of procedures & inadequate training [1910.147]; failure to provide adequate point of operation guarding [1910.217(c)]; failure to provide & enforce use of hand tools to free stuck work [1910.217(d)(1)(ii)]; failure to provide instructions & training on modifications made to press [1910.217(e)]; failure to train & supervise operators in safe operating procedures [1910.217(f)(2)]; improper wiring [1910.303(b)(1)]; failure to provide training & procedures on safety-related work practices [1910.332 & .333]; failure to provide emergency stop control near point of operation [5205.0865].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4022 Serious Injury	7/6/04 Coon Rapids	Power Press Operator	Sheet Metal Work 3499 332999 90	Employee reached over the top of the barrier guard to remove parts from the dies, hit foot trip and received crushing injury to two fingers of left hand.	Serious citations for: mode selector switches not capable of supervision [1910.217(b)(7)(iii)], lack of protection of die setters [1910.217(b)(7)(iv)], improper air control valves [1910.217(b)(7)(xi)], point of operation not effectively guarded [1910.217(c)(1)(i)& 1910.217(c)(2)(i)(a)], inadequate die clamping methods [1910.217(d)(7)], lack of effective die setting procedures [1910.217(d)(9)(i)], lack of press inspections [1910.217(e)(1)(i) &(e)(1)(ii)], lack of training for individuals responsible for the care, maintenance, and repair of presses [1910.217(e)(3)], lack of training of press operators [1910.217(f)(2)].
4023 Serious Injury	7/14/04 Moorhead	Factory worker	Manufactures blowers 3564 333412 35	Mfg. bucket elevators - Installing gear box on head pulley section of bucket elevator, when unstable equipment tipped over, crushing pelvis and both legs.	Serious citation under general duty clause for failure to implement adequate safety procedures, failure to use additional bracing, and inadequate training [182.653 subd. 2].
4024 Serious Injury	7/26/04 Plymouth	Laborer	Rubber Products 3061 326291 100	Employee was filtering heptane through paper towels and the heptane ignited. A secondary fire occurred when one of two nearby alcohol barrels ruptured. Employee suffered burns.	Serious citations for: having alcohol barrels in an exit route [1910.37(a)(2)]; failure to ground containers to reduce sources of ignition [1910.106(e)(6)(i)]; failure to have approved electrical equipment in required areas [1910.106(e)(7)(i)(b) & (c)].
4025 Serious Injury	7/26/04 Bloomington	Mechanic	Boat dealer 5551 441222 5	Employee was testing motor in water tank, and was overcome by exposure to exhaust fumes (carbon monoxide).	Serious citations for: exposure to carbon monoxide, failure to establish respiratory program or feasible administrative or engineering controls [1910.1000(a)(3) & (e), 1910.134(a)(2)]; failure to implement Right-to-Know program & training, failure to provide MSDS [5206.0700, subps. 1(B) &2, .0800, subp. 1].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4026 Fatality	7/29/04 Brooklyn Park	Laborer	Road construction 1611 238910 130	A crew was repaving and doing patchwork on a residential street. Two dump trucks were parked about 50 feet apart. The victim was working near a trailer, then moved in front of one of the dump trucks and started working. Another employee got into the truck, started pulling away from the curb and ran over the victim.	Serious citations for: failure to train all employees exposed to mobile earth-moving equipment in safe work practices, failure to provide a training program developed by a competent person, inadequate training program on safe work practices pertaining to mobile earth-moving equipment, not requiring an employee to wear a high visibility vest or garment while working on the ground and exposed to mobile earth-moving equipment [5207.1000 subp. 2 (A,B,C) and subp. 4]
4027 Serious Injury	8/2/04 Maple Grove	Laborer	Sewer Contractor 1623 237110 45	Employee was pressure testing pipes in a sanitary sewer 35 feet below ground when he started to feel dizzy and weak, and was unable to climb out by himself.	No citations issued. Illness not work-related.
4028 Fatality	8/21/04 Ponsford	General Labor	Boy Scout Camp 7032 721214 220	Victim was disconnecting buoys from a cable that was anchored to the bottom of lake. No floatation device was used. Victim drowned.	Serious citations for: failure to require employees to wear personal flotation devices & have a throw-ring available [182.653, subd. 2]; failure to implement specific procedures for end of season task (AWAIR) [182.653, subd. 8].
4029 Fatality and 1 Serious Injury	8/30/04 Marshall	Painters	Painting Contractor 1721 238320 125	Victims were working from a suspended scaffold on a water tower when the scaffolding collapsed and fell, causing two employees to fall approximately 85', and a third employee to hang from his fall protection equipment.	Willful citations for: scaffold not capable of supporting weight, and not designed by qualified person [1926.451(a)(1) &(2)]; support devices not adequately designed [1926.451(d)(5)(iii)]; platform not securely fastened [1926.452(p)(2)]; scaffold not inspected & components were damaged or weakened [1926.451(f)(3) & (4)]; lack of fall protection & PPE [1926.451(g)(1)(ii) &.28(a)]. Serious citation for failure to train employees by a qualified/competent person [1926.454(a) & (b)].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4030 Fatality	9/6/04 Hutchinson	Operator	Coated & Laminated Paper Manufacturing 2671 322222 16,552	Employees were threading a machine. The employee located on the first floor engaged the machine to continue the threading process while an employee on the third floor was in a hazardous area, removing debris from a vacuum roller. The employee on the third floor was pinned between the vacuum roller and threader bar.	Serious citations for: lack of LOTO procedures [1910.147(c)(4)(i) & (ii)]; failure to provide machine guarding [1910.212(a)(1)].
4031 Fatality and Serious Injury	10/1/2004 Mankato	Millwright	Steel Erection 1791 238120 300	A steel I-beam slipped out of a beam clamp on an overhead crane, and struck and killed the employee. The I-beam also struck and shattered the ankle of a second employee.	Serious citations for: no AWAIR program [182.653, subd. 8]; hooks and latches used in steel erection were not visually inspected; tightening handle was bent [1926.753(c)(1)(i)(E)]; failure to use hooks with self-closing safety latches [1926.753(d)(2)(i)]; failure to use qualified riggers [1926.753(d)(2)(iii)].
4032 Fatality	10/5/2004 Minneapolis	Demolition worker	Demolition 1795 238910 8	A demolition worker was digging a shallow trench at the base of a concrete foundation wall, when a section of the wall (24 cubic ft., 3600 lbs.) gave way and crushed the employee.	Willful citations for failure to conduct an engineering survey by a competent person prior to starting demolition work [1926.850(a)]; failure to shore or brace walls where employees are required to work within a damaged structure to be demolished [1926.850(b)]. Serious citations for lack of an AWAIR program [182.653, subd. 8]; failure to initiate & maintain safety & health programs & provide for safety inspections of the jobsite & failure to instruct employees in recognition & avoidance of unsafe conditions [1926.20(b)(1) & (2) & 1926.21(b)(2)];failure to provide protective equipment and lack of RTK program [1926.95(a) 7 5206.0700, subp. 1(B)].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4033 Serious Injury	9/10/2004 Chaska	Assembler	Manufacturer 3594 333996 120	The employee was operating a bar shear. While lining up a piece of metal, the employee engaged the foot petal and the hold-down pinned the employee's finger to the table surface. The employee's finger was amputated.	Serious citation for failure to guard moving machinery parts [1910.212(a)(1)].
4034 Serious Injury	10/13/04 Monticello	Punch Press Operator	Metal Stamping 3469 332116 4	The punch press operator reached into the press to adjust material and inadvertently depressed the foot control. The machine cycled and amputated 3 middle fingers.	Serious citations for: no AWAIR program [182.653, subd. 8]; failure to guard power press [1910.217(c)(1)(i)]; failure to regularly inspect all parts, auxiliary equipment and safeguards of clutch/brake mechanisms and maintain inspection records [1910.217 (e)(1)(i) & (ii)]; failure to train employee responsible for caring, maintaining, and inspecting punch presses [1910.217(e)(3)]; failure to train punch press operator [1910.217(f()(2)].
4035 Fatality	10/19/04 Crookston	Dozer Operator	Site Prep Contractors 1629 238910 80	The victim was found under a pile of sand dumped from a dump truck. The victim had been missing for about one hour when fellow employees became concerned and started investigating the site.	No citations issued. No standards violated.
4036 Fatality	11/2/04 Fridley	Crane Operator	Bldg. Ext. Contractor 1791 238190 8	Outriggers were not deployed on a truck-mounted crane. The crane tipped over, and the crane's boom crushed an employee.	Serious citations for failure to instruct employees in the recognition & avoidance of unsafe conditions [1926.21(b)(2)]; failure to deploy outriggers [1926.550(b)(2)].
4037 Fatality	11/4/04 St. Paul	Vet Tech	Hospital 8062 622110 2000	Employee was trapped inside steam washer used to clean animal cages while the washer was in the final rinse cycle. The employee could not open the door from the inside, could not stop the washer, and was fatally burned.	Serious citations for having exit route doors that could not be opened at all times without keys, tools, or special knowledge [1910.36(d)(1)]; failure to guard points of operation [1910.212(a)(3)(ii)]; failure to equip machine so that it is possible to cut off power without leaving the position at the point of operation [5205.0865].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4038 Serious Injury	11/11/04 Otsego	Engineer-in-Training	Engineering Services 8711 541330 40	Engineer employee was run over by the two left rear tires of a grader going in reverse. Employee suffered broken bones and collapsed lung.	Serious citations for: no RTK program or training [5206.0700]; lack of training programs & training in safe procedures & hazard recognition for mobile earth-moving equipment operators & employees exposed to equipment [5207.1000, subp. 2(A & B)]
4039 Fatality	08/19/04 St. Paul	Laborer	Paper Mill 2621 322121 300	Employee was crossing street on a private road on the work site and was struck by a truck.	No citations issued. No standards violated.
4040 Serious Injury	11/8/04 St. Paul	Youth Worker	Youth Program 8322 624110 27	An employee who was carrying pot of stew slipped and fell. The hot stew caused 1st, 2nd, and 3rd degree burns on hip, back, legs and arm.	No citations issued. No standards violated.
4041 Serious Injury	12/13/04 Belle Plaine	Production Worker	Pharmaceutical Mfg. 2834 325412 14	Employee was cleaning a batch mixer when the employee inadvertently contacted the start button, causing unexpected startup of the mixer that crushed the employee's hand.	Serious citations for no LOTO procedures or training [1910.147(c)(4)(i) & (c)(7)(i)]; electrical components installed in wet locations were not weatherproofed [1910.350(e)(1) & (2)]; no disconnect switch on mixer [1910.305(j)(4)(ii)(F)]; start button not protected from unintentional activation [5205.0880].
4042 Fatality	12/17/04 Renville	Elevator Operator	Grain Wholesaler 5153 424510 40	An employee driving a truck entered a covered driveway area to unload soybeans. The driver failed to lower the truck box on the way out, striking the overhead door, and concrete above the door frame. The door and concrete header collapsed onto the cab and crushed the driver.	Serious citation for failure to have an AWAIR program [182.653, subd. 8].

2004 MNOSHA Fatality and Serious Injury Investigation Summary Log *(updated through March 31, 2005)*
Note: Citations reflect those originally issued following investigation

Log # Type Insp. #	Date of Incident City	Employee Occupation	Type of Business SIC NAICS Size of Business	Description of Accident	Result of MNOSHA Investigation
4043 Serious Injury	12/21/04 Brooklyn Park	Press Setup Operator	Metal Stamping 3469 332116 27	Employee was adjusting the lower die for a stamping job when the employee inadvertently stepped on the treadle, causing the press to stroke, resulting in a crushing injury to employee's right little finger.	Serious citations issued for failure to develop, document and utilize LOTO procedures and failure to train on LOTO procedures [1910.147(c)(4)(i) and 1910.147(c)(7)(i)]; failure to establish die setting procedure for mechanical power presses and failure to establish a periodic and regular inspection program for mechanical power presses [1910.217(d)(9)(i) and 1910.217(e)(1)(i)]. Nonserious citation issued for failure to conduct an annual or more frequent inspection of LOTO procedure [1910.147(c)(6)(i)].
4044 3 Fatalities 1 Serious	12/28/04 Anoka	Bank & Building Owner Employees	Bank 6022 522110 40	A building exploded due to a natural gas leak that migrated into the building. The building housed 2 employers; 3 employees died and one suffered serious injuries.	No citations issued. No standards violated.